Claim for Compensation On Account of Traumatic Injury or Occupational Disease

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee Statement

1. Name of Employee Last	First	Middle	2. OWCP File Number
Thomas	Betty	B.	00-0000

3. Social Security Number	4. Period of wage loss for which compensation is claimed From mo. day yr. Thru mo. day yr.	Hours	5. Is this a claim for a schedule award?
000-22-1111	12 12 96 — 13 15 96	256	☐ Yes ☒ No

6. Has any pay been received for period shown in Item 4?	7. If yes, amount	From mo. day yr.	Thru mo. day yr.
☐ Yes ☒ No			

8. Was claim made against 3rd party?	9. Name of 3rd party or insurance carrier
☐ Yes ☒ No	

10. Has the claim been settled? Give amount recovered.	Address
	City / State / Zip

11. Have you ever applied for or received benefits from the Veterans Administration based on disability incurred while serving in the Armed Forces of the United States? ☐ Yes ☒ No If Yes, furnish >	a. Claim number	b. Address of VA office where claim is filed	c. Nature of disability and monthly payment

12. Have you applied for or received an annuity under the U.S. Civil Service Retirement Act or any other Federal Retirement or Disability Law? ☐ Yes ☒ No If Yes, furnish >	a. Claim number	b. Date annuity began mo. day yr.	c. Amount of monthly payment $

Dependents

13. List your dependents

Name	Date of Birth mo. day yr.	Relationship	Living with you? (yes/no)	Mailing Address, If different from your own
N/A				

14. Support information for above dependents

Are you making support payments for a dependent shown above? ☐ Yes ☐ No

15. Were support payments ordered by a court? If so, attach copy of court order. ☐ Yes ☐ No

16. If yes, support payments are made to: Last First Middle

Street

City State Zip

17. Amount Per

Signature of Employee

18. I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed, and every statement above is true to the best of my knowledge and belief.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation under the Federal Employees' Compensation Act, or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

Employee's signature Betty B. Thomas Date (Mo., day, year) 3/18/96

19. Employee's home mailing address (Include Zip Code)

Street 6337 Ashley Lane

City Springfield State VA Zip 22015

Figure 810-16, CA-7

Form CA-7

Statement of Official Superior

20. Pay Rate As Of: 12/18	a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)
Date of Injury 12/18	$ 10.25 per hr.	$ N/A per	$ N/A per	$ N/A per
Date Employee Stopped Work	$ per	$ per	$ per	$ per

21. If employee received additional pay, identify type and show amount

☐ Premium Pay N/A per ☐ Night Pay N/A per

☐ Sunday Pay N/A per ☐ Other (Identify) per

22. Show work schedule for week pay stopped
☐ Sun ☒ Mon ☒ Tue ☒ Wed ☒ Thu ☒ Fri ☐ Sat

23. Did employee work in position for 11 months prior to injury? ☒ Yes ☐ No

24. If not, would position have afforded employment for 11 months but for the injury? ☐ Yes ☐ No

25. Total length of federal civilian service Yrs. 15 Mos. 6

Health Benefits and Optional Life Insurance

26. Was the employee enrolled in a Health Benefits Program on the date pay stopped? ☒ Yes ☐ No

If yes, give code 3 0 1

Ending date of the pay period in which HBS / OLI Deductions were last made? mo. 2 day 10 yr. 96

27. Was the employee enrolled in an Optional Life Insurance Program on the date pay stopped? ☒ Yes ☐ No

If yes, was employee enrolled in Option ☒ A ☐ B ☒ C

If Option B, show number of multiples

Leave and Continuation of Pay

28. Type and inclusive dates employee received leave for any part of period since stopping work. Specify type of leave, SICK, ANNUAL, or OTHER

Type of Leave	From mo. day yr.	Thru mo. day yr.	Type of Leave	From mo. day yr.	Thru mo. day yr.
Type of Leave LWOP	From 2 2 96	Thru 3 15 96	Type of Leave	From	Thru

29. If employee received continuation of pay (COP), give dates.

COP 12/19/95-2/1/96

30. Date all pay stopped mo. 2 day 2 yr. 96 Hour 8:30 ☒ AM ☐ PM

31. Period for which compensation is claimed From mo. 2 day 2 yr. 96 Thru mo. 3 day 15 yr. 96

Return to Duty

32. Date returned to work mo. 3 day 16 yr. 96 Hour 8:30 ☒ AM ☐ PM

33. Work schedule when returned to work
☐ Sun ☒ Mon ☒ Tue ☒ Wed ☒ Thu ☒ Fri ☐ Sat

34. Did the work assignment change because of disability resulting from the injury? Describe. ☐ Yes ☐ No

35. Pay rate on return to work $ 10.46 Per hr.

Certification

36. A supervisor who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Signature of supervisor Carolyn M. Smith Date 3/18/96

Supervisor's title Employee Relations Specialist

Agency name & address Dept. of Army, 6666 High Ave. Washington, DC 2041 Office phone 202-219-8888

37. If OWCP needs specific pay information the person who should be contacted is ☒ Supervisor ☐ Other: Name 810-B-48 Phone

Figure 810-16 continued. CA-7

Dec 96

Attending Physician's Report

DoDr 1400.25-M

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Record of Examination

1. Patient's name Last	First	Middle	2. Date of Injury mo. day yr.	3. OWCP File Number	OMB No. 1215-0 Expires: 9-30-91
DAY, Donald L.			2 10 94	A31-0114444	

4. What history of injury (including disease) Did patient give you?

Employee fell from scaffold injuring right ankle.

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) ☐ Yes ☐ No — ICD-9 Code

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

Sprained right ankle.

7. What is your diagnosis? — ICD-9 Code

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer) ☒ Yes ☐ No

9. Did injury require hospitalization? If no, go to item #12	10. Date of admission mo. day yr.	11. Date of discharge mo. day yr.	12. Additional Hospitalization require If Yes, describe in "Remarks" (Item 25)
☐ Yes ☒ No			☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination mo. day yr.	15. Date(s) of treatment mo. day yr.	mo. day yr.	mo. day yr.	16. Date of discharge from treatm mo. day yr.
2 10 94	2 10 94			

17. Period of total disability From mo. day yr. Thru mo. day yr.	18. Period of Partial Disability From mo. day yr. Thru mo. day yr.	19. Date employee able to resum light work mo. day yr.
	2 10 94 — 3 12 94	2 11 94

20. Date employee is able to resume regular work mo. day yr.	21. Has employee been advised that he/she can return to work?	22. If yes, on what date was he/she advise mo. day yr.
3 13 94	☒ Yes ☐ No	3 12 94

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #24 if necessary.)	24. Are any permanent effects expected as result of this injury? If yes, describe in item #24. ☐ Yes ☒ No

25. Remarks

26. If you have referred the employee to another physician provide the following: Name / Address / City State Zip	Specialty / 27. What was the reason for this referral? ☐ Consultation ☐ Treatment

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

Signature of Physician _____ Date _____

29. Name of Physician / Address / City State Zip	30. Tax ID Number / 31. Do you specialize? ☐ Yes ☐ N / 32. If yes, indicate specialty

Dec 96

Claim for Compensation On Account of Traumatic Injury or Occupational Disease

U.S. Department of Labor DoD 1400.25-M
Employment Standards Administration
Office of Workers' Compensation Programs

Employee Statement

1. Name of Employee Last	First	Middle	2. OWCP File Number
Smith	Joseph	P.	02-22200

3. Social Security Number	4. Period of wage loss for which compensation is claimed From mo. day yr. Thru mo. day yr.	Hours	5. Is this a claim for a schedule award?
688-00-2682	04 01 96 — 09 06 96	1096	☐ Yes ☒ No

6. Has any pay been received for period shown in item 4?	7. If yes, amount	From mo. day yr. Thru mo. day yr.
☐ Yes ☒ No		

8. Was claim made against 3rd party?	9. Name of 3rd party or insurance carrier
☐ Yes ☒ No	
10. Has the claim been settled? Give amount recovered.	Address
	City State Zip

11. Have you ever applied for or received benefits from the Veterans Administration based on disability incurred while serving in the Armed Forces of the United States? ☐ Yes ☒ No If Yes, furnish >	a. Claim number	b. Address of VA office where claim is filed	c. Nature of disability and monthly payment

12. Have you applied for or received an annuity under the U.S. Civil Service Retirement Act or any other Federal Retirement or Disability Law? ☐ Yes ☒ No If Yes, furnish >	a. Claim number	b. Date annuity began mo. day yr.	c. Amount of monthly payment $

Dependents

13. List your dependents

Name	Date of Birth mo. day yr.	Relationship	Living with you? (yes/no)	Mailing Address, if different from your own
Mary E. Smith	03 31 50	Wife	Yes	

14. Support Information for above dependents Are you making support payments for a dependent shown above? ☐ Yes ☐ No	15. Were support payments ordered by a court? If so, attach copy of court order. ☐ Yes ☐ No
16. If yes, support payments are made to: Last First Middle	
Street	
City State Zip	17. Amount Per

Signature of Employee

18. I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed, and every statement above is true to the best of my knowledge and belief.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation under the Federal Employees' Compensation Act, or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

Employee's signature Joseph P Smith — Date (Mo., day, year) 9/9/96

19. Employee's home mailing address (Include Zip Code)

Street 812 South Jefferson Street

City Newark State New Jersey Zip 028051

Form CA-7

Figure 810-17. Form CA-7

Statement of Official Superior

20. Pay Rate As Of:	a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)
Date of Injury 4/1/96	$ 25.00 per hr.	$ NA per	$ NA per	$ NA per
Date Employee Stopped Work 4/1/96	$ 25.00 per hr.	$ per	$ per	$ per

21. If employee received additional pay, identify type and show amount

☐ Premium Pay NA per ☐ Night Pay NA per

☐ Sunday Pay NA per ☐ Other (Identify) NA per

22. Show work schedule for week pay stopped
☐ Sun ☒ Mon ☒ Tue ☒ Wed ☒ Thu ☒ Fri ☐ Sat

23. Did employee work in position for 11 months prior to injury? ☒ Yes ☐ No

24. If not, would position have afforded employment for 11 months but for the injury? ☐ Yes ☐ No

25. Total length of federal civilian service Yrs. 14 Mos. 09

Health Benefits and Optional Life Insurance

26. Was the employee enrolled in a Health Benefits Program on the date pay stopped? ☐ Yes ☒ No

If yes, give code

Ending date of the pay period in which HBS / OLI Deductions were last made? mo. day yr.

27. Was the employee enrolled in an Optional Life Insurance Program on the date pay stopped? ☐ Yes ☒ No

If yes, was employee enrolled in Option ☐ A ☐ B ☐ C

If Option B, show number of multiples

Leave and Continuation of Pay

28. Type and inclusive dates employee received leave for any part of period since stopping work. Specify type of leave, SICK, ANNUAL, or OTHER

Type of Leave	From mo. day yr.	Thru mo. day yr.	Type of Leave	From mo. day yr.	Thru mo. day yr.
Sick Leave	04 01 96	07 15 96			
Type of Leave	From	Thru	Type of Leave	From	Thru
Annual Leave	07 16 96	09 06 96			

29. If employee received continuation of pay (COP), give dates.

NA

30. Date all pay stopped mo. day yr. NA Hour : ☐ AM ☐ PM

31. Period for which compensation is claimed From mo. day yr. Thru mo. day yr.

Return to Duty

32. Date returned to work mo. day yr. 09 09 96 Hour 7 : 30 ☒ AM ☐ PM

33. Work schedule when returned to work
☐ Sun ☒ Mon ☒ Tue ☒ Wed ☒ Thu ☒ Fri ☐ Sat

34. Did the work assignment change because of disability resulting from the injury? Describe. ☐ Yes ☒ No

35. Pay rate on return to work $ 25.00 Per hr

Certification

36. A supervisor who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Signature of supervisor Samuel Gills Date 09-15-96

Supervisor's title Budget Officer

Agency name & address Dept of Defense, Pentagon Office phone

37. If OWCP needs specific pay information the person who should be contacted is ☐ Supervisor ☐ Other: Name Phone

Figure 810-17 Continued

Attending Physician's Report

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Record of Examination

1. Patient's name Last	First	Middle	2. Date of Injury mo. day yr.	3. OWCP File Number	OMB No. 1215-0103 Expires: 9-30-91

4. What history of injury (including disease) Did patient give you?

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) ☐ Yes ☐ No — ICD-9 Code

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

7. What is your diagnosis? — ICD-9 Code

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer) ☐ Yes ☐ No

9. Did injury require hospitalization? If no, go to item #12 ☐ Yes ☐ No	10. Date of admission mo. day yr.	11. Date of discharge mo. day yr.	12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25) ☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination mo. day yr.	15. Date(s) of treatment mo. day yr. mo. day yr. mo. day yr.	16. Date of discharge from treatment mo. day yr.

17. Period of total disability From mo. day yr. Thru mo. day yr.	18. Period of Partial Disability From mo. day yr. Thru mo. day yr.	19. Date employee able to resume light work mo. day yr.

20. Date employee is able to resume regular work mo. day yr.	21. Has employee been advised that he/she can return to work? ☐ Yes ☐ No	22. If yes, on what date was he/she advised? mo. day yr.

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #24 if necessary.)

24. Are any permanent effects expected as a result of this injury? If yes, describe in item #24. ☐ Yes ☐ No

25. Remarks

26. If you have referred the employee to another physician provide the following:
Name
Address
City State Zip

Specialty

27. What was the reason for this referral? ☐ Consultation ☐ Treatment

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

Signature of Physician _____ Date _____

29. Name of Physician
Address
City State Zip

30. Tax ID Number

31. Do you specialize? ☐ Yes ☐ No

32. If yes, indicate specialty

Form CA-20

Figure 810-17 Continued

Dec 96

Attending Physician's Report

U.S. Department of Labor CA-20.25-M

Employment Standards Administration
Office of Workers' Compensation Programs

Record of Examination

1. Patient's name Last	First	Middle	2. Date of Injury mo. day yr.	3. OWCP File Number	OMB No. 1215-0103 Expires: 9-30-91
DAY, Donald L.			2 10 94	A31-0114444	

4. What history of injury (including disease) Did patient give you?

Employee fell from scaffold injuring right ankle.

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe)
☐ Yes ☐ No

ICD-9 Code

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

Sprained right ankle.

7. What is your diagnosis?

ICD-9 Code

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer)
☒ Yes ☐ No

9. Did injury require hospitalization? If no, go to item #12	10. Date of admission mo. day yr.	11. Date of discharge mo. day yr.	12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25)
☐ Yes ☒ No			☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination mo. day yr.	15. Date(s) of treatment mo. day yr.	mo. day yr.	mo. day yr.	16. Date of discharge from treatment mo. day yr.
2 10 94	2 10 94			

17. Period of total disability From mo. day yr. Thru mo. day yr.	18. Period of Partial Disability From mo. day yr. Thru mo. day yr.	19. Date employee able to resume light work mo. day yr.
	2 10 94 — 3 12 94	2 11 94

20. Date employee is able to resume regular work mo. day yr.	21. Has employee been advised that he/she can return to work?	22. If yes, on what date was he/she advised? mo. day yr.
3 13 94	☒ Yes ☐ No	3 12 94

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #24 if necessary.)	24. Are any permanent effects expected as a result of this injury? If yes, describe in item #24.
	☐ Yes ☒ No

25. Remarks

26. If you have referred the employee to another physician provide the following: Name / Address / City State Zip	Specialty / 27. What was the reason for this referral? ☐ Consultation ☐ Treatment

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

Signature of Physician _____ Date _____

29. Name of Physician / Address / City State Zip	30. Tax ID Number / 31. Do you specialize? ☐ Yes ☐ No / 32. If yes, indicate specialty

Form CA-20
Rev. Oct. 1988

Figure 810-18. Form CA-20 Attending Physician's Report

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION FOR LOSS OF WAGES OR PERMANENT DISABILITY CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A NARRATIVE MEDICAL REPORT OR A FORM CA-16 TO OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA 1500/OWCP-1500a.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-31 ON THE FORM; AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 16; AND
3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Information Management, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

For Sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

*U.S. Government Printing Office: 1991 — 526-172

Figure 810-18 Continued

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not qualify for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

EMPLOYEE (or person acting on the employee's behalf) - Complete items 1 through 19 and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) - Complete items 20 through 37 and promptly forward the form to OWCP.

ITEM EXPLANATIONS - Some of the items on the form which may require further clarification are explained below:

Item Number	Explanation
4) Period of Wage Loss for which Compensation is Claimed	Enter inclusive dates covering the period for which you are claiming compensation. If intermittent periods are claimed, use a separate sheet to list each period individually.
5) Is This a Claim for a Schedule Award?	Schedule awards are paid for permanent impairment to a member or function of the body. A claim for a schedule award should not be made on the same form as a claim for compensation for wage loss; rather, a separate CA-7 should be used.
6) Has Any Pay Been Received for Period Shown in Item 4?	This question includes leave pay and COP received from the Federal job in which you were injured; and pay for work actually performed, whether at the Federal job in which you were injured or at other employment (including self-employment).
7) If Yes, Amount	Give the amount of pay received and the period for which it was paid. If there is more than one period, or more than one source of pay, explain fully on a separate sheet.
8) Was Claim Made Against 3rd Party?	A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
13) List Your Dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he or she either lives with you or receives support payments from you, and he or she: 1) is under 18; or 2) is between 18 and 23 and is a full-time student; or 3) is incapable of self-support due to physical or mental disability.
21) If Employee Received Additional Pay, Identify Type and Show Amount	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
28) Type and Inclusive Dates Employee Received Leave for Any Part of Period Since Stopping Work	Enter inclusive dates covering each period of leave. If leave was used for more than four individual periods, continue on a separate sheet. If leave was used for part of each day during a period, state how many hours were used per day; if the number of hours used per day varied, use a separate sheet to list each day.
29) Dates of Pay Continuation (COP) During Period of Disability	Enter the period of Continuation of Pay (see form CA-1 for a full explanation). If the injury was not a traumatic injury reported on form CA-1, this item does not apply.
30) Date All Pay Stopped	No compensation is payable for temporary total disability until the employee enters a non-pay status; therefore, item 30 refers to termination of all pay, including leave. Compensation is not payable for the first three days of disability after the end of any COP unless the disability exceeds 14 calendar days.

Figure 810-18 Continued

FORM CA-20, PHYSICIAN'S REPORT

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should detach Form CA-20, complete items 1-3 on the front, and print the OWCP district office address on the reverse. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.304). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association **Guides to the Evaluation of Permanent Impairment.**

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or have complied with the provisions of 20 CFR 10. (4) Furnishing all requested information will facilitate the claims adjudication process; and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.

Figure 810-18 Continued

Instructions for Completing Form CA-7, Claim for Compensation on Account of Traumatic Injury or Occupational Disease with CA-20, Attending Physicians Report

PART A. The employee or employee's representative completes Items 1 through 19.
Employees:
Item 1. Enter your last name, first name, and middle name (if no middle name, enter "NMN").
Items 2-3. Self-explanatory.
Item 4. Enter beginning and ending dates of time lost due to injury and hours claimed. If claiming schedule award, enter "NA."
Item 5. If the injury has resulted in a permanent loss of some part of the body or partial loss of function of some part of the body, enter "yes." The OWCP will base the schedule award on the percentage of impairment. Refer to Section 8107 of the FECA for compensation schedule.
Item 6. Self-explanatory.
Item 7. Enter total amount and the period covered.
Item 8. Check appropriate box. Complete a. or b. if applicable.
Item 9. If yes, provide complete address, including 9-digit ZIP code.
Item 10. Self-explanatory.
Item 11. Self-explanatory.
Item 12. Check appropriate box. If yes, provide information requested in a., b., and c.
Item 13. Check appropriate box. If yes, provide information requested in a., b., and c.
Item 14. List all relatives (including adopted children) who depend on you for support. A spouse living with you is considered a dependent whether or not he or she is financially dependent on you.
Items 15-16. Self-explanatory.
Item 17. List to whom support payments are made.
Item 18. Indicate amount paid out for each dependent and the frequency of payments.
Items 19-20. Self explanatory.
Part B. The supervisor completes Items 20 through 37. Supervisors:
Item 21. Enter pay rate as of the date of injury and as of the date employee stopped work.
Item 22. If applicable, obtain premium pay from payroll for one year before DOI. If information is not readily available, indicate that premium pay has been requested and will be forwarded upon receipt.
Item 23. Indicate the scheduled workdays for the week in which pay stopped. Enter "NA" if pay has not stopped.

Item 24. Check appropriate box.
Item 25. Enter "no" only if a temporary employee.
Item 26. Include all federal civilian service.
Items 27-28. Self-explanatory.
Item 29.
a. Enter the beginning and ending dates of any annual or sick leave used. If time was intermittent, attach a list of dates lost and type of leave taken.

Figure 810-19. Instructions for Completing Form CA-7.

b. Enter any dates the employee received holiday pay, administrative leave or any paid leave category other than sick or annual leave.
Item 30. Enter the period or periods the employee received COP, including nonduty days and holidays if the period of COP spans such days.
Item 31. Enter month, date, year and time employee's pay stopped.
Item 32. Enter beginning and ending dates for which compensation is claimed.
Item 33. Enter month, date, year and time employee returned to work.
Item 34. Indicate work schedule when employee returned to work.
Item 35. If employee has returned to a light-duty assignment or other assignment as a result of the injury, describe the specific functions employee is performing.
Item 36. Enter pay rate of employee upon return to work.
Items 37 and 38. Self-explanatory.
NOTE: If not previously submitted, attach a copy of position description and physical requirements (SF 78) for the job held on DOI and Application for Employment from the OPF.

Special Note: CA-20 should be attached to Form CA-7 to support claim being made.

Figure 810-19 Continued. Instructions for Completing Form CA-7.